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The Transition to Permanent PACE

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I. INTRODUCTION

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare managed care benefit that addresses the problem of fragmentation of acute and long-term care financing and provision for frail Medicare beneficiaries. The primary goal of PACE is to prolong the independence and enhance the quality of life of frail Medicare beneficiaries. In PACE, interdisciplinary teams assess participants' needs for PACE-covered benefits; develop customized care plans; provide all the benefits included therein, either directly or through contractors; and continually monitor participants' health and well-being. Because PACE is a managed care program, teams can develop plans of care without regard for usual Medicare coverage restrictions.

The Balanced Budget Act of 1997 (BBA) established PACE as a permanent entity within the Medicare program and authorized states to provide PACE services to beneficiaries dually eligible for Medicare and Medicaid as a state option. Having operated as demonstration programs, PACE organizations first began transitioning to permanent status in 2002. This report describes the permanent PACE organizations and how permanency affected PACE organizations' operations. Other reports estimated the effects of PACE on care quality (Beauchamp et al. 2008) and public costs (Foster et al. 2008), relative to a comparison group of recipients of Medicaid home- and community-based services (HCBS) in seven states.

A THE PACE PROGRAM

PACE is a Medicare managed care benefit intended to prolong the independence and enhance the quality of life of frail beneficiaries by providing solutions to the service delivery problems encountered by those who remain living in the community. To achieve that end, the PACE model attempts to (1) integrate participants' long-term care, medical care, and social services; (2) grant physicians and other providers more flexibility in the way they care for participants; and (3) continually monitor the health and well-being of participants. In PACE, interdisciplinary teams continually assess participants' needs for PACE-covered benefits; develop and coordinate customized care plans; and provide all the benefits included therein, either directly or through contractors. (Table I.1 lists the minimum PACE benefits package.) Free from Medicare's usual coverage restrictions, PACE teams can deviate from Medicare regulations. For example, PACE can develop plans of care designed to improve or maintain functioning, whereas in traditional Medicare home health, providers can only plan services that are expected to improve functioning. Finally, except for care in inpatient hospitals, nursing facilities, medical specialties, or in the home, most benefits are delivered in adult day health centers run by PACE organizations. Day center attendance provides a social opportunity for participants and is meant to allow staff to identify and address problems before complications develop. PACE staff may also care for participants in the home, hospital, or nursing home, and the organization provides transportation both to the PACE center and to other providers.

To be eligible for PACE services, a beneficiary must be at least 55 years of age, a resident of a PACE organization's service area, and certified by the state Medicaid agency as eligible for nursing home level of care. Eligible beneficiaries, who voluntarily enroll in PACE, agree to forgo their usual sources of care and receive all their services through the PACE organization and its contractors.

TABLE I.1

MINIMUM REQUIRED SERVICES FOR PACE ORGANIZATIONS

Interdisciplinary assessment and treatment planning
Primary care services, including physician and nursing services
Social work
Restorative therapies
Personal care and supportive services
Nutritional counseling
Recreational therapy
Transportation
Meals
Medical specialty services
Laboratory tests, X-rays, and other diagnostic procedures
Drugs and biological
Prosthetic and durable medical equipment, corrective vision devices, hearing aids, and dentures
Acute inpatient care
Nursing facility care

Source: 42 CFR Part 460.90, Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE); Final Rule.

PACE organizations accept capitated per-member per-month payments from Medicare and Medicaid for each eligible enrollee. Medicare participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount.[1] In exchange for this pooled funding stream and freedom from coverage restrictions, PACE organizations assume full financial risk for all of the participants' care, without limits.

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[1] Beginning in 2006, these participants were also required to pay a Medicare Part D premium.

B. DATA SOURCES

This report draws primarily on site visits conducted by MPR researchers to eight PACE organizations in summer and fall 2005. At the time, there were 25 PACE organizations operating in 14 states.[2] The site visits were designed to collect information on how PACE operations changed as well as how some organizations incorporated community-based physicians into their operations, a practice that was unusual and required a special Centers for Medicare and Medicaid (CMS) waiver at the time. (PACE physicians are generally employees of the PACE organization.) The states were chosen to complement the states in which empirical analyses were conducted: we visited California, Colorado, Maryland, Massachusetts, New York, Ohio, South Carolina, and Texas. We selected specific PACE organizations as follows:

Colorado, Maryland, South Carolina, and Texas each have only one PACE organization, so we visited all four of them. These organizations are Total Long Term Care in Denver, Hopkins ElderPlus in Baltimore, Palmetto Senior Care in Columbia, and Bienvivir Senior Health Services in El Paso.

Multiple PACE organizations operate in Massachusetts and Ohio. We visited Harbor Health Services in Boston and Trihealth SeniorLink in Cincinnati, after selecting them at random.

Multiple PACE organizations also operate in California and New York. We visited On-Lok in San Francisco and Comprehensive Care in New York City because they used community-based physicians. (Information on how community-based physicians were used in PACE organizations was reported in Cheh 2006.)

In each organization we interviewed the PACE director, medical director, center manager, director of finance, and at least two members of the interdisciplinary team, such as a social worker and nurse. Before each visit, we reviewed the organization's application to become a permanent PACE provider and the final PACE Program Agreement between the organization, CMS, and the state administering agency. While visiting the organization, we requested copies of current marketing materials, forms used to assess participants and develop care plans, organizational charts, lists of contractors, financial statements from the last three years, and any existing reports on participant characteristics.

II. WHAT IS PERMANENT PACE?

Permanent PACE organizations play two roles in the Medicare program. First, they are a provider of comprehensive acute and long-term care services. Second, they provide health insurance services, assuming full financial risk for the costs of those services while receiving a capitated payment from Medicare and Medicaid. Although the PACE organizations have different components that are defined by CMS regulations, other factors that shape PACE

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[2] As of December 2009 there are 70 PACE organizations operating in 30 states. For a list of permanent PACE providers, see http://www.cms.gov./PACE/LPPO/list.asp#_Top_ofPage.

organizations include state regulations, local markets for long-term care and medical services, and each organization’s experience with what works well and what does not. This section identifies the regulations that govern permanent PACE and then examines the model as it exists in the eight sites we visited in 2005.

A. PACE REGULATIONS

CMS issued PACE regulations in 1999 and 2002, basing them on the demonstration protocol that established the key PACE structural and operational elements. The 1999 regulation specified, among other things, eligibility, administrative requirements, application procedures, services, payment, participant rights, and quality assurance. The regulation also defined a role for states in PACE administration. Thus, states that include PACE as an option in their Medicaid plans must (1) designate an agency to serve as an administrative liaison between PACE organizations and CMS, (2) decide whether to limit the number of participants that may be enrolled in PACE at any given time, and (3) certify that PACE participants need the level of care provided in the state’s nursing facilities. The 2002 regulation sought to give PACE organizations more operational flexibility. It allows them to request waivers of federal regulatory requirements as long as requests are consistent with the “essential elements” of PACE. The five elements that are statutorily defined as essential to PACE and cannot be waived are (1) the focus on frail elderly people who require the level of care provided in nursing facilities; (2) integration of acute and long-term care services; (3) the team approach to care management and service delivery; (4) capitated, integrated financing; and (5) the PACE organization’s assumption of full financial risk (Federal Register 2002).

The final rule was published in December 2006 and took effect in January 2007. This final rule includes additional requirements as set forth in the Medicare Modernization Act of 2003; these rules were not known at the time we conducted the site visits to the PACE organizations and are not covered in this report.

B. BASIC FEATURES OF EIGHT ORGANIZATIONS

The regulations set out the basic features of the PACE organizations, including the ownership and size of the organizations, how the organizations could be marketed, the structure of the interdisciplinary teams, the delivery of services, and the approach to quality assurance and payments. We will discuss each of these below.

1. Ownership and Size. PACE organizations, by statute, can only be operated as not-for-profit organizations, but they can be part of a larger not-for-profit system. These larger systems will influence the PACE organization, as the larger system will affect both the financial resources and managerial support available to the PACE organizations. The eight PACE organizations we visited all are private, not-for-profit organizations, but they operate under different ownership arrangements and vary in size. Three were owned by health care systems that operated other community-based long-term care programs, three were owned by hospital systems, and two were independent. The organizations were serving 145 to 1,085 participants when we visited them, with four serving fewer than 500 and two serving more than 1,000. Two of the organizations operated one day center, two operated three, two operated five, and two operated eight. Four of the organizations were subject to state-imposed enrollment caps. Three of those said the caps constrained them, but the other, which serves a non-urban target area, was having difficulty building census.

2. Marketing. PACE organizations need to have a sufficient level of enrollment to generate enough revenue to cover their costs; but being managed care organizations, they also have the incentive to try to enroll the "least costly" of the potential participants. As a result, CMS wants to ensure that the PACE program materials are clear and distributed widely. PACE marketing regulations specify that PACE organizations must (1) include certain information in their promotional materials, (2) obtain CMS approval of all such materials, (3) meet the language requirements of the community they serve, and (4) establish and implement a marketing plan with measurable objectives.

PACE organizations generally targeted outreach efforts to the families of prospective participants because experience has shown that family members influence enrollment decisions. The PACE organizations marketed themselves with a variety of tools. All conducted grassroots outreach activities such as making presentations or having information booths at local health fairs, church events, and senior center functions. The organizations distributed brochures at these venues, and some also had posters, informational CD-ROMS, and videos. A few used paid advertising, most commonly in neighborhood newspapers and senior-services directories, but also on radio and television. One organization planned to produce t-shirts for members of its consumer advisory committee. The shirts will read "Need help with Mama or Daddy?" on the front and the PACE organization's name and phone number on the back. Two organizations mentioned that the vans they used to take participants to and from the day centers, which have the PACE organization's name painted on the side, were good publicity.

PACE organizations used different marketing strategies depending on whether they were trying to maintain or grow their census. An organization serving the maximum number of participants allowed under its state cap said it did minimal marketing and deliberately prolonged its enrollment process (to about two months) in hopes a slot would become available for the prospective participant. In contrast, an organization intent on rapid growth sought broad publicity (it invited reporters to PACE center events, for example) and cultivated relationships with referral sources (such as hospital discharge planners).

We did not see a relationship between organizational ownership and availability of marketing resources. One hospital-owned organization said its owner paid for and helps it develop "the expensive stuff" such as brochures, posters, and videos. But the organization that was planning to make t-shirts is doing so because *its* hospital owner would not finance billboard advertising. Of the two independent organizations we visited, one tried to grow its census and seemed to have adequate marketing resources available, but the other was operating at capacity and, as a result, needed only minimal marketing resources.

3. Interdisciplinary Teams. One of the key designs of the PACE program is that an interdisciplinary team that communicates regularly about the care needs of an individual will identify issues early, allowing for the provision of timely, coordinated services. PACE organizations are statutorily required to use an interdisciplinary team (IDT) approach to care management and service delivery. At a minimum, each IDT must include a primary care physician, registered nurse, social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietitian, PACE center manager, home care coordinator, personal care attendant or a representative, and driver or a representative. The PACE regulation holds the IDT collectively responsible for conducting participants' initial assessment and periodic reassessments, developing each participant's plan of care, and coordinating 24-hour care delivery. Although the regulation holds the primary care physician responsible for managing medical situations, PACE organizations and IDTs decide for themselves which team member(s) lead meetings and facilitate discussion.

All but two of the PACE organizations we visited augmented their IDTs with one or two additional disciplines. Pharmacists were part of the IDTs at six sites. A nursing technician, clinical psychologist, and dental director were each on teams at one site. Of the eight organizations we visited, four have some team members serving on more than one team.

IDT meetings feature prominently in the workday of PACE team members. The organizations we visited typically begin each weekday with a meeting. One site's morning meetings include information on the following:

- Staff "call offs" (those not coming to work)
- Participant call offs (those not coming to the day center as scheduled)
- A report from the previous night's on-call staff
- A report on falls or other incidents involving participants
- Reviews of participants in hospitals or nursing facilities
- Special announcements
- Reviews of care plans for any new participants

Separate meetings are held to develop care plans and conduct periodic reassessments. Most organizations said these care planning/reassessment meetings were held weekly. In addition, several organizations ask IDT members to serve on committees and subcommittees to steer quality-improvement initiatives; thus, many team members also attend committee meetings.

Although the IDTs assessed themselves as working well together at most of the PACE organizations we visited, establishing a well-functioning team was not automatic. Instead, most organizations established procedures to facilitate teamwork. To develop a participant's care plan, for example, team members typically take turns presenting the results of their assessment and making service recommendations specific to their discipline. Other team members from different disciplines then chime in with their opinions. When disagreements arise, teams at some organizations try to reach consensus through discussion. Some teams vote and go with the majority's decision. Some discuss the matter but ultimately defer to the discipline in question, and some teams consult the center manager, program director, or other management-level staff. Although we commonly heard that all disciplines on the IDT were on a "level playing field" during care plan meetings, a couple of organizations mentioned that adapting to the team approach is sometimes difficult for physicians. Physicians are trained to give orders rather than negotiate, we were told, and some do not find case management to be as satisfying as the technical aspects of practicing medicine.

4. Service Delivery at the PACE Center. Regulations require that many PACE services—namely, primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals—be furnished in PACE day centers. Services also are provided where participants live—at home or in assisted living facilities, nursing homes, or hospitals. They may be provided by PACE employees or contractors.

The PACE regulation holds the IDT responsible for determining the frequency of participants' attendance at the centers. Indeed, none of the organizations we visited had firm *a priori* attendance requirements. Attendance was instead determined by the center's occupancy limits, whether participants had opportunities to socialize elsewhere, the participants' desire to attend, and their health status and medical needs. Occupancy thresholds forced some centers to set priorities about the types of participants who could visit the center and how frequently. For example, participants who were alone during the day took priority over those who resided in assisted living facilities, where they could socialize and be monitored. Occupancy limits aside, participants who were near death or were receiving long-term care in a nursing home may never have gone to the day center. Participants who were extremely obese or prone to great anxiety while in the day center also were not required to attend. On the other hand, participants requiring a great deal of monitoring or assistance, such as those with poorly controlled diabetes or complex medication regimens, could attend the center daily.

Staff members reported that participants who visit the day centers do so two to three times a week, on average.[3] At a minimum, IDTs encouraged most participants to visit the center for a monthly clinical check-up. Although staff members emphasized that check-ups can be performed wherever participants live, only about five percent of participants never visit the day centers. One organization asked participants to visit the day center at least weekly during the first three months of enrollment in order for the IDT to get to know the participant. In addition, the request conveyed to prospective participants that visiting the day center is a basic expectation of PACE. Understanding this expectation helped prevent beneficiaries from joining for the wrong reason (for example, joining to obtain a specific benefit, such as dentures, that a neighbor was known to have received through PACE).

PACE centers were thought to be important not only for service delivery and monitoring but also for the socialization and stimulation of participants. Socialization comes about naturally to some extent—we witnessed many warm interactions between staff members and participants during our visits—but PACE organizations also work hard to create opportunities for participants to interact. A couple of the organizations we visited serve culturally diverse populations and purposely schedule participants' visits to coincide with the visits of others who share their background or speak their language. One organization contracted with a nearby adult day center because the staff members there speak the language spoken by about 10 percent of the organization's participants. (Those participants visit the PACE center only for clinic visits.) PACE organizations helped keep participants engaged and stimulated, for example, by keeping therapy dogs on the premises; hosting visiting pet programs; and, at one site, offering yoga classes, field trips, and photography clubs.

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[3] "Visiting" the day center generally means staying there for most of the day, especially the core hours between 10:00 a.m. and 2 p.m. Transportation logistics dictate this.

5. Delivering In-House Versus Contract Services. PACE organizations always or almost always provided some services through contractual arrangements. These include hospital, nursing home, laboratory, durable medical equipment, and specialty medical services. By contrast, there was considerable variation in whether they provided other services, such as transportation, rehabilitation, end of life care, and home health care, in house or through contract partners.

Transportation and home health aroused discussion from a couple of organizations that had switched from contractual to in-house provision. In the case of transportation, one organization explained that contracting out for transportation was expensive and restricting—drivers could provide no more than curb-to-curb service. After the switch, the organization's own drivers helped participants transfer if needed and reminded them to bring their pill trays to the center. The same organization that switched from contractual to in-house transportation services also used half as many contracted home health aides as it once did. It found it had much better control over care quality for the aides it employed than it did over aides employed by contractor agencies. Participants who were homebound or had a history of falls received services from PACE aides, whereas less risky participants received services from agency aides. Another organization planned to phase out all agency aides for similar reasons. Otherwise, none of the PACE organizations that provided transportation or home health care through contracts expressed dissatisfaction with their contractors.

6. Quality Assessment and Performance Improvement. Federal regulations require PACE organizations to write quality assessment and performance improvement (QA/PI) plans and to implement QA/PI programs that address and improve the full range of PACE services. At the PACE organizations we visited, QA/PI included ongoing activities and special initiatives. Six of the organizations had staff members devoted full-time to QA/PI. At the others, the executive director or center director oversaw QA/PI.

PACE organizations collected data to meet CMS reporting requirements and their own information needs. The organizations we visited typically collected data on utilization (admissions, readmissions, and length of stay in hospitals and in nursing homes and emergency room visits) and process outcomes (medication adherence, cancelled appointments, preventive screenings, and flu shots). One medical director explained that the quality indicators she monitored are subject to continual change, depending on their usefulness for influencing care. For example, the organization stopped tracking key indicators for diabetes quality of care because they were always reaching their goal of 100 percent compliance. Although the organization's board of directors liked seeing such good statistics, the medical director convinced the board that monitoring adverse outcomes (such as diabetic comas) would be more productive.

PACE organizations also ensured that contractors did their jobs safely and effectively on an ongoing basis. They monitored the quality of care provided by institutional contractors in the course of their customary visits with participants and through periodic site visits. One organization asked its assisted living facility contractors to report adverse incidents and submit monthly "task sheets" that itemized services provided to PACE participants. Another says its home health agency and transportation contractors willingly submitted reports of complaints from PACE participants. In return, PACE sent the contractors newsletters with participant satisfaction results geared toward their staff (drivers or home health aides, as the case may be).

One organization conceded that it did not actively monitor its hospital and physician specialist contractors because it trusted these longtime contractors; and even if it didn't trust the contractor, the PACE organization felt it did not have any leverage to bring about changes at these organizations. This PACE organization operated in a market that had a severe shortage of health care professionals, and thus the physician groups could easily replace any revenue they lost from the PACE organization.

PACE organizations undertook special QA/PI initiatives in response to problems identified by IDTs or reflected in the data they collected. The vice president for quality initiatives at one organization said teams come to her with a plan in mind and she asks how the QI department can support the plan. At another organization, all staff members convened annually to brainstorm about special QA/PI initiatives they could launch in the coming year. Everyone votes, and the top two or three choices get implemented. The special initiatives mentioned during our site visits include those to prevent falls; improve wound care; encourage the use of advance directives and end-of-life services; improve environmental safety; improve care for participants with dementia; and improve medication, pain, and post-hospital discharge management. Two organizations said they had become the go-to experts on fall prevention in the hospital systems they are part of.

7. Payment and Financial Management. PACE organizations are required by federal regulations to accept capitated monthly payments from Medicare, Medicaid, and private sources.[4] Capitated financing is intended to allow providers "to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems," according to CMS (2005). At the same time, however, PACE organizations bear full financial risk for all the services participants use for as long as they are enrolled.[5] PACE organizations must demonstrate to CMS that they are fiscally sound in terms of cash flow, liquidity, and solvency.

The PACE organizations we visited depended almost entirely on Medicare and Medicaid revenues and had at most a handful of private-pay participants. Six of the eight organizations we visited said revenues exceeded costs in the last fiscal year. Of the six whose revenues exceeded costs, two had recently experienced three- to six-month periods of financial difficulty, which they attributed in part to low enrollment.

Many factors can make financial management difficult for PACE organizations. For example, Medicaid payments may not keep up with inflation. One organization said its Medicaid

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[4] The Medicare monthly capitation rate is defined in each organization's agreement with CMS. Since 2004, the rate paid has been a blend of two formulas: (1) the Medicare Advantage county rate multiplied by a uniform PACE frailty factor and (2) a risk-adjusted payment methodology. The blend transitioned to a 100 percent risk adjustment in 2008. The Medicaid monthly capitation rate is negotiated between the PACE organization and the state Medicaid agency and is contractually specified. Medicare beneficiaries who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount.

[5] Unlike many other long-term care programs, PACE participants who enter nursing homes remain in the PACE program, and PACE pays for nursing home services unless the participant disenrolls from the PACE program.

payment had not increased since 2001. Another said its Medicaid payment had been reduced several years earlier and had just been restored to the pre-reduction amount. Other factors pertain to the needs, desires, and behavior of participants. At the time of our site visits, one organization's previous-quarter costs were $300,000 higher than budgeted because three participants needed costly services (such as the engagement of numerous specialists and hospital care to address an atypical illness). Another organization said direct-to-consumer advertising for durable medical equipment and prescription drugs increased participant demand for these items. Another emphasized that PACE had limited control over participants. Noncompliance can lead to costly complications, but all PACE can really do is educate participants and their families about behavioral risks and work with them to try to change their behaviors. The behavior of contractors and IDTs can also make it difficult to control costs. Being owned by a teaching hospital means "everything is accessible" in terms of medical tests and services, and PACE struggles to "reign in" hospital doctors who prescribe them.[6] The executive director at another organization said the IDTs believe federal regulations require them to "take care of all needs" regardless of cost effectiveness. This kind of thinking, she said, led a team to give a full set of dentures to an 85-year-old participant who neither reported dental problems nor had trouble eating. Finally, insufficient enrollment leads to insufficient revenues. We visited one organization that was 16 participants (or about five percent of the total enrollment) shy of being able to break even financially.

As challenging as financial management can be, PACE organizations did find ways to control costs. Several organizations mentioned that bringing services in house made it easier to control costs: Pharmacy, home health and home care, and transportation were mentioned in particular. Two organizations mentioned that communicating with participants' families is important. PACE organizations can educate family members about their role in keeping the participant in the community, for example, and about the implications (for costs and quality of life) in choosing certain end-of-life treatments. In addition, families who are encouraged to state up front their expectations about the participant's care plan are less likely than others to ask for more, according to one organization we visited. Writing good contracts, purchasing prescription drugs through the federal 340B Pharmaceutical Discount Program, and teaching IDTs to focus on the participants' needs and make good decisions (and not just follow usual treatment patterns) were also cited as cost-control measures by the organizations we visited.

C. STAFF PERCEPTIONS OF ESSENTIAL PACE FEATURES

Since the original On-Lok demonstration, the PACE program has been evolving, and what is considered an essential feature of a PACE program has changed over time and across organizations. During site visit interviews, executive directors, medical directors, and center managers spoke about the core features that they believed—in practice—defined the PACE model.

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[6] Note that although PACE employs the primary care doctor, many specialists that are included in the PACE network are not employed by the PACE organization.

All of the staff agreed that the flexibility to provide whatever services “make the most sense” for a given participant was critical to the PACE model, and it was most commonly cited as key to helping participants stay independent and live in the community. As one executive director described, regular Medicare covers physical therapy in a nursing home only as long as the beneficiary makes progress toward the therapeutic goal. Coverage, and thus therapy, stops if the beneficiary reaches a plateau. If the beneficiary then regresses in the absence of therapy, it is costly to regain lost ground. PACE teams, on the contrary, can decide to continue therapy when a patient plateaus, thus preventing lapses. PACE provides better care from a participant perspective and more cost-effective care from a financial perspective.

PACE day centers were not mentioned as essential to the model, especially as more PACE organizations offer “PACE at home” (for those who do not attend the day center on a regular basis) and cover participants as they reside in nursing homes.[7] In rural areas, transporting geographically dispersed participants to a centralized day center may be challenging and prohibitively expensive. Even in urban areas, some respondents said, it can make more sense for participants who live close to senior centers or adult day care facilities to receive social services, recreation, and meals in those locations instead of a PACE center further from home. That way, participants avoid having to be transported by van; PACE saves transportation costs; and importantly, the participant interacts with others in his or her own community. Providing more home-based care appealed to some PACE organizations, one reason being that, with more and more participants needing wheelchairs, transportation becomes costly and time consuming.

PACE’s team-based approach to assessment, planning, and service delivery was generally considered a core feature, though it was thought to be overkill in some circumstances. At its best, the team approach helps PACE participants live in the community longer by moving the locus of care from the physician and spreading it among all team members. Whereas a physician treating a participant on his or her own might prefer hospitalization over home-based care, the PACE model “allows the physician to delegate” and not be solely responsible for making sure a participant can be safely cared for in the home. At its worst, the team approach is wasteful, respondents said. Not all disciplines will contribute meaningfully to all assessments and reassessments. If a prospective participant has no apparent signs of nutritional deficiencies, should a dietitian still be compelled to assess him or her? If a participant begins a temporary nursing home stay, is it the best use of resources for every IDT member to go to the nursing home for a face-to-face reassessment? One organization believes that, in most cases, nurses are the best people to assess needs and authorize care decisions, leaving other IDT members to implement the plan of care rather than develop it.

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[7] PACE participants in nursing homes may still attend the center, but in some cases it is difficult for and disruptive to the participants to leave their nursing home.

IV. HOW DID PERMANENCY AFFECT PACE OPERATIONS?

As described in Chapter II, BBA established PACE as a permanent part of the Medicare program and permitted states to provide PACE services to Medicaid beneficiaries as a state option. This process involved updating and refining the PACE demonstration protocol as well as adhering to the BBA requirements that instructed CMS to consider the requirements established for Medicare Plus Choice (M+C).[8]

Because PACE organizations were new organizations that provided a complete range of acute, long-term care and social services, the PACE regulations had to cover an extensive range of issues as well as address the issues that concerned the managed care insurance component of PACE. Indeed, the regulations covered such basics as the basis, scope, and definition of PACE; how organizations could become a PACE organization; what the PACE program agreements required; and how PACE regulations would be enforced. It also defined the PACE administrative requirements (administrative, governing body, personnel qualifications, training, program integrity, contracted services, physical environment, infection control, transportation, dietary, fiscal soundness. and marketing) and PACE services (benefits and required services, excluded services, the IDT, participant assessments and plans of care). It included regulations on participants' rights; enrollment and disenrollment; and the PACE programs requirements for quality assessment and improvement, payment, data collection, and federal/state monitoring. The ways in which the PACE regulations clarify, modify, add to, deviate from, and adhere to the PACE demonstration protocol are summarized in "PACE Protocol Influence on the PACE Regulation" (CMS 2005).

Despite the wide arrange of issues addressed in the PACE regulations, few of these regulations deviated substantially from the PACE demonstration protocol; hence PACE organizations were not expected to make major operational changes to conform. However, conforming PACE to the M+C regulations was a new requirement and thus was more likely to affect the PACE organizations.

During our 2005 site visits, we asked PACE staff members whether and how the transition to permanent PACE affected various aspects of PACE operations. This chapter summarizes our findings about how easy or difficult it was for demonstration sites to become permanent PACE providers. It then describes staff members' assessments of the ongoing effects of the regulations. Our main findings are the following:

PACE organizations spent a substantial amount of time preparing documents needed to obtain permanent-provider status. Many organizations commented that, in general, the PACE

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[8] As noted earlier, PACE was not established as a Medicare Plus Choice Program (M+C), the predecessor to the current Medicare Advantage Program. However, the BBA instructed CMS to consider the requirements established for M+C when developing the regulations for the PACE organizations.

regulation overemphasizes documentation, although some acknowledge that this also reflected the extensive scope of services provided by a PACE organization.

As expected, most areas of operations remained about the same thereafter; thus most organizations felt that the change to permanent PACE had little effect on their day-to-day operations.

The sole exception was that most organizations reported that the regulation on handling participant grievances requires much more work for staff members; a few consider the regulation to be counterproductive.

A. THE TRANSITION TO PERMANENT PACE

Most of the PACE organizations we visited became permanent providers in 2002 and 2003. Staff members' recollections of the transition centered on the great amount of paperwork involved in preparing the CMS application. Application preparation included writing narrative responses to CMS questions—typically a document of about 100 pages—and assembling supporting materials. Materials included organizational charts, sample marketing materials, QA/PI plans, statements of participant rights, and sample care plans and assessment tools. Most organizations assigned responsibility for preparing the application to one or two staff members.

The organizations we visited said that, in addition to preparing the application per se, it was time-consuming and sometimes difficult to interpret the regulations, determine whether the organization was already compliant, and if not, determine how it could become so. Writing policies that addressed the regulations used an "immense amount of time" was a typical comment. However, many noted that they were able to resolve the issues with help from CMS and the National PACE Association.

Although becoming a permanent provider in the Medicare program was expected to take time and effort, the encompassing mission of PACE—to be both a health insurer and a provider of acute health care, long-term care, and social services—made it particularly challenging. As one provider noted, though the paperwork requirement for permanent PACE was extensive, the state had even more onerous requirements as a result of all the different departments that had regulatory authority over PACE. The provider noted that had PACE just been an HMO, or just been a provider of health services, the requirements would likely be fewer.

B. ONGOING EFFECTS OF FEDERAL REGULATIONS

Once an organizations obtained CMS approval of its application and had secured a three-way PACE agreement (among the organization, CMS, and the state administering agency), it began operating as a permanent provider. For the most part, these 2002 regulations did not change the majority of the PACE organizations' operations. However, a few of the regulations did affect individual organizations, and although these organizations made changes to comply with the rules, they also had reasons for preferring to operate differently. Below we describe how these individual organizations changed to meet the permanent PACE requirements in the areas of PACE administration, participant rights, and PACE services—the three areas cited in our visits.

1. Administration. The PACE administrative requirements defined the PACE organizational structure, governing body, personnel qualifications and training, program integrity, contracted services, infection control, transportation, dietary services, fiscal soundness and marketing (Sections 460.60–460.82). In all of these regulations, there were four areas where PACE organizations changed their operations to meet the permanent requirements: the requirement that the PACE centers offer the full range of PACE services, the requirement for a consumer advisory board, personnel requirements, and the marketing requirement.

PACE Center. Two of the eight organizations we visited said they had to change in response to the requirement that all PACE centers offer the full range of PACE services from primary care to meals. The first organization had been operating "recreation centers" in residential buildings to provide therapy, meals, and socialization to PACE participants who lived in those buildings. Staff from the full-service centers rotated through the recreation centers so that participants would see familiar faces when they needed to visit the PACE clinic. The recreation centers were meant to be convenient for participants and to free them from having to rely on transportation to the full-service center; but because they were not compliant with 1999 regulations, the recreation centers are no longer used. The second organization had planned to open a small day center (without a primary care clinic) to serve participants with advanced Alzheimer's disease. The providers at this PACE organization believe that participants with Alzheimer's must be segregated from other participants to ensure their safety and must visit the PACE center five days a week, primarily for caregiver respite. Because the 1999 regulations thwarted these plans, the organization now provides more home-based care to this group of participants.

Consumer Advisory. Another regulation that changed operations was the requirement that the PACE organization have a consumer advisory committee advise its board of directors. One organization said it switched from using several center-based consumer advisory committees to a single organization-wide committee to comply with the federal requirement. Whereas it had made sense for the committees to resolve problems at the center level because problems arise at that level, bringing relatively mundane concerns (such as driver tardiness) to the attention of the board of directors seems a misuse of the board's time. The organization said attempts to educate committee members about the types of issues that might be more appropriate for board-level discussions were not successful, in part because committee membership changed frequently.

Personnel Qualifications. The PACE regulations clarified some of the personnel qualifications for members of the IDT. For the majority of the PACE organizations, the staff they had in place met the requirements, and the organizations agreed that the regulations were appropriate. Adhering to requirements about personnel qualifications, staff training and evaluations, and oversight of contracted staff is a hardship for some organizations, but adherence also has benefits.

The regulatory requirements about personnel qualifications (such as credentialing or previous experience) were difficult to meet for some of the PACE organizations in specific circumstances. One reported difficulty hiring master's level social workers because it could not compete with the salaries offered by a large, well-established nursing home in its service area. Another said it had difficulty hiring registered nurses because of competition from area hospitals, which offer signing bonuses. That organization typically received only one or two resumes per nurse vacancy. Two organizations were hampered by the requirement that drivers have experience transporting individuals with special needs. One was fortunate when the hospital that owned the PACE organization reduced the number of drivers it employed, giving the PACE organization sudden access to a lot of experienced drivers. The other PACE organization had an in-house training program for drivers. It planned to request a waiver from the experienced driver rule on the grounds that its in-house program has long produced safe, qualified drivers.

Requirements that PACE organizations ensure that staff members demonstrate relevant participant care skills and develop a competency evaluation program that evaluates those skills were described by some organizations as useful and by others as a nonproductive burden. Some organizations said they had retooled their programs for training and evaluating staff members because of the regulations and that doing so had improved patient care. Others said they had already had effective practices in place and the regulations added nothing but the burden of documentation. For example, one organization said that if it hired a nurse whose blood-drawing skills needed refreshing, it would send the nurse to work in its hospital affiliate for a day, during which time he or she would perform about 70 blood draws. Now, in addition to arranging the hands-on experience, PACE is required to document its practice to the satisfaction of CMS. Another organization considers the training requirements for unskilled staff, such as personal care attendants, overly stringent. Because of the requirements, two weeks typically elapse before new hires interact directly with patients.

The greatest staffing-related burden reported by PACE organizations, however, stems from having to ensure the competency of contracted providers. Such regulations befit an HMO that works solely as an insurer and does not have direct experience with its contracted staff, one staff member explained, but not a provider like PACE that works closely with and monitors its contractors daily. Other respondents argued that because most contractors are already regulated by a state licensing agency or other credentialing body, PACE organizations should not have to do more. It’s putting another layer upon a layer of regulation already on the provider.

Marketing and Other Requirements. The PACE organizations we visited reported that they were constrained by requirements in three areas: (1) marketing and intake materials, (2) enrollment start dates, and (3) recertification of eligibility.

According to the organizations we visited, federal regulations about marketing and intake materials result in descriptions of PACE that are not helpful to consumers making care decisions. For example, several organizations said the 1999 regulation was too restrictive about the language PACE organizations can use in marketing materials. In particular, the organizations said their introductory brochures would benefit from using plain English about eligibility rather than the required language that PACE is for people with health problems that “qualify them for Nursing Facility Care as determined by the state” and who live “in the community.” Prospective participants and their caregivers are already familiar with nursing homes, but PACE is a new concept for them. Thus, to compete with nursing homes, especially when families are in crisis and must make a rapid decision about enrollment, PACE organizations need to be able to market themselves with language that is meaningful to consumers.

Moreover, enrolling in PACE takes too long for families in crisis, we were told during site visits. Whereas families can arrange nursing home admissions in a matter of days, the PACE intake process can easily last a month, given the requirement of interdisciplinary assessments. Moreover, no matter when new PACE participants sign enrollment agreements, their enrollment does not become effective until the first day of the following month, according to the 1999 regulation. Families who cannot or do not wish to wait such a long time opt for nursing home care instead of PACE.

The 1999 regulation’s annual recertification requirement was described as detrimental to participant and staff morale at a few of the PACE organizations we visited. Up to eight participants who wished to remain in PACE had not met eligibility criteria upon recertification in the past year, meaning the state had determined they no longer required nursing home care. Although some of these participants successfully appealed the decisions, other participants heard about the cases and feared for their continued enrollment. One executive director called the phenomena a “perverse psychological impact” that might evince a desire not to become “too well.” Another organization pointed out that while nursing homes in the state are not subject to recertification requirements, PACE loses participants if it does its job well.

2. Participant Rights. Sections 460.110–460.118 of the regulations address participant rights. Although most of these corresponded to the organizations’ previous practices, as we noted in the introduction to this chapter, regulatory requirements for grievance procedures were commonly described as problematic for PACE organizations.

Nearly all the PACE organizations we visited were of the opinion that the nomenclature and level of documentation required for handling “grievances” are a burden to staff and a disservice to participants. Requiring that the term “grievance” be applied to all expressions of dissatisfaction deters participants from voicing complaints, as does having to fill out a grievance form. One quality assurance director told us she is convinced staff members hear about fewer problems than they should because participants usually do not want to file formal grievances. They fear they will get a staff member in trouble or they might be retaliated against.

For staff members, documenting grievances, providing written notification about the resolution process, and documenting the resolution can be extremely time-consuming, especially when correspondence must be translated into languages other than English. One organization told us that if a participant complains during lunch at the PACE center that the peas are cold, the organization’s first action is to resolve the problem by giving the participant another vegetable. However, because federal regulations dictate that even “cold peas complaints” (as this organization has come to refer to expressions of minor dissatisfaction) be described and treated as grievances, the organization presents the participant with a form to document the problem and its resolution, and it includes the offense in reports to CMS. Because the outcome of complaints remains the same from the participant’s perspective, some organizations believe the documentation accomplishes nothing. Only one organization said participants like seeing minor complaints documented. Another said that although the paperwork required for the grievance process takes time, there are “no short cuts” to figuring out what works and what does not.

3. PACE Services. The PACE regulations stipulated the required services, including the service delivery mechanisms, emergency services, the composition of the IDT, participant assessment, and plans of care. (Sections 460.90–460.106). The PACE organizations generally agreed that the majority of the participant care regulations were appropriate and had no effect on continuing operations. However, some organizations indicated that documenting all aspects of participant care, including discussions thereof, was burdensome. PACE’s team approach to care was sometimes described as too heavily regulated.

The comments we heard about documenting participant care were similar to those about documenting grievance processes: Because the care outcome is the same, the documentation seems superfluous. One organization said it has always documented team meetings, but the requirement to record all information exchanges between team members in individual participant charts is laborious. Moreover, this organization thinks that documenting participant care on a daily basis (which stems from the requirement that teams continuously monitor participants) makes sense during acute care episodes, but not during long-term care. Some participants have been enrolled in that PACE organization for 10 years; documenting “all the little things they have going on” uses a lot of paper and time, but does not affect care delivery.

Some of the staff members who took part in site visit interviews think the PACE model’s team approach to care is wasteful at times. In particular, some consider it an unnecessary formality to require all team members to contribute to assessments and reassessment in all instances. A spike in a participant’s blood sugar should trigger a reassessment, one organization explained, but not by every discipline on the team.

C. SUMMARY

Despite the comprehensiveness of the 1999 and 2000 regulations and the initial effort required to become a permanent provider, PACE operations stayed the same more than they changed, according to the organizations we visited. For example, after organizations wrote the policies and procedures needed for the PACE application, no organization reported significant changes with regard to the structure of their governing body, the physical environment of PACE centers, the array of benefits provided, the provision of emergency care, internal QA/PI activities, processes for disenrollment, or data reporting.

Most staff members who took part in site visit interviews believed most of the federal regulations were reasonable. Staff members with previous experience in the nursing home industry or Medicare home health care emphasized that PACE was much less regulated in comparison. At best, organizations conceded that the federal regulations gave them the push they needed to formalize procedures. Other organizations believe they were already operating to meet the best interests of participants, then had to accommodate regulations that included much more documentation than they believed was warranted.

V. WHAT MIGHT AFFECT PACE OPERATIONS IN THE FUTURE?

We asked respondents about what regulatory issues they believed might affect PACE care in the future, and all of the sites indicated that they anticipated the introduction of Special Needs Plans (SNPs) might have a direct effect on the PACE program. SNPs are Medicare Advantage Plans that are allowed to target and enroll Medicare beneficiaries who historically have had difficulty coordinating care and funding sources. Congress defined these beneficiaries as those who were (1) institutionalized, (2) dually eligible, or (3) affected by severe or disabling chronic conditions. These plans can serve populations that may also be eligible for PACE, and some respondents were concerned that they could lose participants to SNPs. One respondent felt very strongly that SNPs had a clear advantage over PACE—“that SNPS could offer the same services as PACE, but without being as heavily regulated”—and questioned why anyone would remain a PACE provider if being a SNP was an option. (It should be noted that there are advantages of the PACE program over SNPs, because PACE has Medicaid funding arrangements and control over Medicaid funded services, and SNPs do not. This administrator felt those issues could be overcome.) But most of the providers were undecided about how SNPS might affect PACE and noted that they would be following how the SNP program evolved.

A second issue that one PACE organization raised was the advent of electronic health records and how CMS might accommodate them in the PACE regulations. This organization had already introduced an electronic health record for its participants, and in preliminary testing found that the record—which allowed all the different disciplines to record and share the participant's progress in different areas and alerted all providers when new notes were entered—enabled information to be shared on a continual basis. This organization generally thought that this would enhance the ability of the PACE organization to care for its participants but also noted that it could make the face-to-face staff meetings redundant. The question that this site raised is whether a "virtual" meeting could replace the face-to-face meeting, and whether electronic health records could be used to document the exchange of information between the interdisciplinary team members. Some staff members thought that it might and it could make the PACE program a more efficient way of delivering care.

VI. CONCLUSIONS

Whenever an administrative change, such as the change from a demonstration status to a permanent status, takes place, there is always concern that new rules and regulations could change the program and perhaps adversely affect it. In the case of the PACE program, we found that, in the sites we visited, the conversion process was time consuming but few areas of the program operations systematically changed. Furthermore, the changes that did affect a majority of the organizations—such as requiring written documentation on participants' complaints—were unlikely to affect patient health and functioning outcomes. However, PACE will continue to be affected by other regulations and changes in technology, suggesting that the "permanent" PACE program may need to adapt in the future.

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